

# Introduction: The Connecticut Mental Health Center as a public psychiatry initiative

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This text celebrates the fortieth anniversary of the Connecticut Mental Health Center (CMHC). The CMHC, from its very inception, represented a collaborative effort of the State of Connecticut and Yale University. This unique connection between state and academic interests attended to the psychiatric interests of the public while focusing on ways to advance knowledge and to train students of the mental health professions. It is our contention that this unusual hybrid has had a remarkable history. Further, the CMHC has had a significant impact on psychiatric service models because of the very nature of the organization's identity. The CMHC represents forty years of sustained commitment to the provision of outstanding clinical services to patients in the public sector. These services have also been informed and buttressed by academic initiatives and a focus on the education of future psychiatrists as well as other mental health professionals.

In this volume, we focus on the psychiatric subspecialty of public psychiatry that was practised in a mental health center integrally connected to an academic department of psychiatry and its parent medical school. While this perspective may limit a comprehensive picture of community mental health, we believe it is important to develop the history of academic public psychiatry for both service and academic reasons. We return at the end of this introduction to a discussion of the significance of our effort.

## Definition of public psychiatry

Public psychiatry is that part of psychiatry practised in the public sector and funded by a state's general funds as well as by reimbursement from entitlements such as Medicaid. Services provided by public sector clinicians serve as a safety net for disadvantaged, vulnerable, mentally ill and addicted individuals in the community. For disabled, chronically ill individuals, Medicare may fund services after disability is established

by the Social Security Administration. Public psychiatry is practised in many loci: mental health and addiction agencies; community behavioral health centers and programs; residential and nursing care facilities; rehabilitative and support service agencies; and organizations offering forensic and public health programs. Considering its funding sources, its targeted attention to the poor and seriously, chronically ill, and its breadth of services, the CMHC is clearly a public psychiatry service.

We contend that public psychiatry is a subspecialty of general psychiatry and should be identified as such for educational purposes. In the past 25 years, psychiatry has seen the development of several subspecialties. These include addictions, forensic psychiatry, consultation psychiatry, emergency psychiatry and geriatric psychiatry. All of these have special educational requirements. It is clear to us that public psychiatrists also require specialized education in order to practise competently. Public psychiatrists must understand psychiatric disability and how to complete functional assessments. They must also be knowledgeable about psychosocial and vocational rehabilitation in order to integrate these concepts into comprehensive plans of care. They should appreciate the principle of recovery and should be at ease in their interactions with consumers so as to respond effectively to the needs and aspirations of their patients. Public psychiatrists are expected to collaborate with other community-based professionals providing residential and money management services that support patients outside of the hospital. They must be competent, if not qualified, in the evaluation of addictions and should have a working understanding of legal problems commonly encountered by patients seeking services in the public sector. Psychiatrists working in this arena must be effective members of interdisciplinary teams, often as leaders of a team, and confident about medical roles in both clinic and community settings as well as aware of the roles of other professional groups. Indeed, they must understand how non-traditional mechanisms are employed beyond the clinic for reaching out and serving patients. Psychiatrists in public settings optimally achieve an understanding of systems dynamics and a population perspective on the use of clinical resources. Though these areas of knowledge and competence are obvious to the average psychiatrist in public sector practice and constitute a substantial domain of expertise, we are unaware of any movement at present to define public psychiatry as a subspecialty. Perhaps this volume will give some impetus to such a movement.

Academic public psychiatry concerns itself with the educational preparation of young psychiatrists and other mental health professionals to confront the challenges of public sector practice. It is this young cadre who also will carry out research into pressing questions raised by public sector practice. We wish to emphasize that such scholarship is necessary if public psychiatry is to advance and if its practitioners are to become progressively more skilled. An important task for this text is to show how academic public psychiatrists and other mental health professionals housed at the CMHC have engaged in such scholarly efforts over the past 40 years. They have done so always with an eye on improving practice, thereby benefiting the patients served.

## **Brief history of public psychiatry**

The origins of public psychiatry can be traced to Dorothea Dix and the 19<sup>th</sup> Century. She was instrumental in a movement to bring to a wider public the benefits of moral

psychiatry, which had been responsible for the opening of large, famous private hospitals such as the Institute of Living in Connecticut and Brattleboro Retreat in Vermont. In 1854, President Pierce vetoed legislation passed by Congress that would have created a federal role in providing for seriously ill psychiatric patients, leaving responsibility for the mentally ill in the hands of the states and local communities.

Over the next 50 years, many states opened large hospitals or asylums. The State of Connecticut constructed the Connecticut Valley Hospital and four other state-owned facilities. These became the cornerstones of public sector psychiatric care. Owing to the combination of ineffective treatments, the chronicity of serious disorders and eventual overcrowding, it was difficult to maintain a high level of care in these state facilities. In one reaction to the poor quality of care in large state facilities during the early 20<sup>th</sup> Century, the Yale University graduate Clifford Beers championed development of the mental hygiene movement. Mr. Beers suffered from bipolar disorder and had been hospitalized at Connecticut Valley Hospital. On recovery from his illness, he promoted early intervention and community clinics.

Before World War II, the majority of psychiatric practice occurred in large state hospitals and mental hygiene clinics. The post-World War II era saw the rise of another major reaction to state hospitals, culminating in the community mental health movement of the 1960s and 1970s. That movement was driven by federal policy and initiative as a result of converging forces that included wartime lessons in early intervention, the emergence of new treatments such as chlorpromazine, and considerable optimism. The passage of the Community Mental Health Centers Act in 1963 signaled that a fundamental transformation of psychiatric practice was underway. It heralded the emergence of a new system of care focused on community-based services and predicated on public health concepts. The transformation included the development of 675 community mental health centers. The Hill-West Haven Division, a part of the Connecticut Mental Health Center, was one of them. Meanwhile, state departments of mental health continued to provide services, largely through state hospitals and, to some extent, in newly developed, outpatient clinics supported by the National Institute of Mental Health. In this period, federal policy initiative and investment in the construction and staffing of community mental health centers eclipsed state roles. In the first phase of the community mental health center movement until the mid-1970s, there was little coordination between the new community mental health centers and the old state hospitals and clinics. The public practice of psychiatry during this time was divided between federal and state initiatives.

It is important to note that reimbursement by the newly enacted Medicaid and Medicare legislation in the 1960s led to a significant expansion in the role played by general hospitals in the institutional care of psychiatric patients. Also, the number of nursing homes for long-term care of chronically ill and elderly mentally ill grew enormously. In this way, federal entitlements fostered the development of alternatives to institutional care in large state hospitals. General hospital units and nursing homes became major building blocks in the modern system of care for patients treated in the public sector. As a result of the role played by federal entitlements, it is sometimes difficult to discern where the public sector ends and the private sector begins.

The contemporary concept of public psychiatry emerged during the 1980s. More precisely, it reemerged, as the Community Mental Health Centers Act and movement

wound down. Probably the passage of mental health block grants to states under President Reagan in 1982 marked the change. Public psychiatry in state departments of mental health and state hospitals did not disappear between 1963 and 1982; it receded into the background. Deinstitutionalization was the most prominent movement within state public psychiatry from the 1960s to the 1990s. With the replacement of categorical federal funding with block grants to states in 1982, reinforced by the Community Support Program of the National Institute of Mental Health, state departments of mental health began once again to play a leading role in public psychiatry. In addition, while academic programs organized around community psychiatry were developed and dominated the 1970s, so-called public sector academic programs slowly began to emerge, notably at Columbia University, the University of Massachusetts, the University of Colorado and the University of Oregon. At Yale University, a more gradual transition occurred from academic programs in community psychiatry to programs now called public psychiatry.

During the 1990s, as states pursued federal reimbursement for mental health services, Medicaid policies and regulations began to define the public sector more prominently. This was a time of federal–state collaboration as states submitted plans that were reviewed by the Center for Medicare and Medicaid Services. The types of services and parameters of service were defined by Medicaid regulations, even as states exercised considerable choice over the extent and shape of Medicaid programs. This heralded the reemergence of an indirect federal role as a payer in defining the public sector. The role of payer would prove indicative of future development of services under the assumptions of managed care and privatization.

Progressively, state departments of mental health increasingly transitioned from the role of providing services in state-owned facilities to purchasing services in the community. A large number of private, non-profit agencies thrived because of this change. Their budgets were predominantly made up of state, public money supplemented by revenue from Medicaid and other payers. Tracing the evolution of state budgets for mental health starting in the 1980s, a shift occurred from predominant support for inpatient services to ambulatory services and from state-provided services to services purchased and provided in the community by private, non-profit agencies. Similar to the effects of Medicaid and Medicare in the 1960s, the boundaries and distinctions between public and private sector services blurred even more. It became progressively difficult to discern when, during patients' careers in treatment, they were in the private or public domain.

A federal New Freedom Commission reported in 2003 that the mental health system was in “shambles” and called for a transformation of the system, particularly in the public sector. The New Freedom Commission recommended bringing about systems change by pursuing the following principles: (1) mental health is essential to overall health; (2) mental health is consumer and family driven; (3) disparities in mental health services are eliminated; (4) early mental health screening, assessment and referral to services are common practice; (5) excellent mental health care is delivered and research is accelerated; and (6) technology is used to access mental health care and information. The exact implications of transformation for the public psychiatric system of services in which community mental health centers operate are still unclear.

## The Connecticut Mental Health Center and public psychiatry

The idea of creating the CMHC originated in the 1950s in discussions between the Chairman of the Yale Department of Psychiatry, Fritz Redlich, and Connecticut's Governor Abraham Ribicoff. Initially, the intent was to develop an academic, state institute for clinical demonstration projects and research. The New York State Psychiatric Institute was a reference model in the original discussions. By the time the CMHC opened in 1966, the original concept was already changing under the influence of federal policy. At the CMHC's opening, the relationship between the State of Connecticut and Yale University was codified in a memorandum of agreement, which still serves as a reference point for definition of the missions of the Center as well as the respective responsibilities of the two parties.

The passage of the Community Mental Health Centers Act in 1963 created incentives for Connecticut and Yale University to seek federal support for a "catchmented" center, one that would have responsibility for a specific geographic area. Eventually, the federally funded center known as the Hill-West Haven Division was opened as a clinical division within the larger administrative entity known as the CMHC. Over time the Hill-West Haven Division and federal policies under the 1963 Act dominated the evolution of clinical services at the CMHC. The clinical services of the CMHC also influenced the agenda for education and research.

With block grants starting in 1982 and the reemergence of the Connecticut Department of Mental Health, the CMHC gradually realigned its clinical programs and academic missions with the goals of the state agency. In the early part of this new phase, the principles and policies of the Community Support Program of the National Institute of Mental Health, which disseminated system concepts and clinical programs for chronically ill persons, were a guiding force. Though program diversification began in the 1970s, it was not until the 1990s that the CMHC's services were clearly diversified. This occurred with the emergence of forensic and substance abuse services.

The relationship of the CMHC to the Connecticut Department of Mental Health and Addiction Services and the Yale Department of Psychiatry continues to define the CMHC. It is the State–Yale collaboration that shapes a definition of the multiple missions of the CMHC. The four major missions are clinical services, education, research and community development. This last mission is a function of the Center's location in an urban setting with typical social problems that impinge on the recipients of care. The multiple missions give the CMHC its particular character as an academic community mental health facility.

A staffing contract between the State of Connecticut and Yale University provides for the leadership, medical staff and psychologists (with some nurses and social workers) at the CMHC to be hired by Yale University. All of these professionals are also faculty in Yale's Department of Psychiatry or the School of Nursing. By virtue of this, the CMHC serves as the principal location of faculty in the Department of Psychiatry who concern themselves with academic public psychiatry.

Within the historical framework outlined above, the CMHC presently is a state-owned community mental health center located in a medium-sized urban setting. As

noted, the professional and medical staff of the CMHC hold faculty appointments in the Yale Department of Psychiatry or the School of Nursing while most nurses and other operational personnel are state employees. The CMHC serves over 5000 individuals per year through a variety of clinical programs. The majority of the patients in treatment have disabilities, co-occurring substance abuse problems and legal problems. The clinical programs include acute inpatient services (20 beds); sub-acute, transitional services to housing (10 beds); 12 research beds; a walk-in, evaluation service; an outreach service to homeless persons and to individuals in crisis; a classical, assertive community treatment team; and ambulatory treatment and case management, organized into diagnostic teams. In addition, through satellites, the CMHC has a clinic for substance abuse treatment and a Hispanic clinic dispensing care to monolingual Latinos. The satellites include three community-based clinics in local communities. In one satellite, the CMHC provides services to children and families and operates a special program for late teenagers and young adults from the city who are aging out of child care. Further, the CMHC is a lead mental health agency for 16 community-based agencies that provide vocational and psychosocial rehabilitation, residential services, case management, and family education and support services. The CMHC's budget for clinical services from state general fund dollars was approximately \$26M in fiscal year 2006. The total budget for the CMHC in the same year exceeded \$50M. This latter amount included not only state general fund dollars but also grants obtained by individual faculty.

This text offers a history and an intensive case study of the CMHC, one community mental health center that has highly developed academic programs. While the example of the CMHC is particular, we believe there are both national and international implications and applications of this parochial experience. For example, the book's discussion of the special knowledge, experiences and education in public psychiatry for trainees at the CMHC has implications, joining with other academic centers and the field at large, for national discussions of the value of added qualifications in public psychiatry. Another example is the implication of the discussion in the chapter on chronic mental illness for other community mental health centers, which might be concerned about preserving a focus on a core, target population of patients, while the current agenda in public psychiatry diversifies and multiplies. In general, much of the knowledge and many of the programs described in this book, such as in the chapters on substance use disorders or law and psychiatry, might be applied in public practice.

## **Academic programs in public psychiatry**

In the past 25 years, several fellowships in public psychiatry have emerged for post-residency training of psychiatrists. While not numerous, they reflect recognition of the particular problems that confront professionals in the public sector. Examples of such programs are found at Columbia University, the University of Maryland, the University of Massachusetts and the University of Oregon, to mention a few. The CMHC also offers advanced psychiatric training for research and practice in public psychiatry.

Academic public psychiatry has evolved over the past 40 years. The chapters in this volume provide a summary of where public psychiatry academic programs stand at

present in the CMHC and in the field generally. We will outline our existing programs below as we introduce the chapters in this volume. The present configuration of programs does not represent the service system of the CMHC at its inception. At that time, subjects originating from the 1960s community mental health center movement dominated the agenda. These topics included evaluation of community-based services and catchmenting; organization and management theory; studies of crisis theory; prevention and community services; the role of faith-based services; services research and epidemiology; and the search for new and more effective treatment interventions. Slowly during the early 1970s, research on addictions emerged. It was followed in the late 1970s by an academic program on forensic psychiatry. In the early 1980s, research on chronic illness was consolidated. Each of these recent, academic programs, missing at the outset, now constitutes a major stream of research and teaching at the Center as outlined in chapters that follow.

Certain themes in public psychiatry cut across the organization of our academic programs. These include concern with treatment in the community as opposed to that meted out in the hospital, the debate concerning outpatient commitment, comparisons between old and new antipsychotic medications, the integration of clinical treatments and rehabilitation, challenges evoked by the recovery and the consumer movements, the introduction of patient-centered care, the integration of mental health and addictions treatments to address the problems of co-occurring disorders, the utility of service systems, state-owned versus private non-profit ownership, and the problem of shrinking mental health care budgets. These subjects, more or less particular to public psychiatry, are supplemented by general movements in American health care that include patient safety, discrepancies in health care outcomes for ethnic minorities, quality management and ownership of health benefits. These themes will be considered in more than one chapter. The concluding section will create a synthesis of these threads and will ultimately suggest a direction for the evolution of public psychiatry.

The book has been structured so as to represent, through its chapters, major programs at the CMHC. These programs encapsulate at once both clinical and academic initiatives. All of the chapters' authors have had extensive connections to the CMHC.

Chapter 1, *Severe and Persistent Mental Illness*, will trace the development of an academic program that started with John Strauss and Courtney Harding in the 1980s. It will cover both theoretical and practical approaches to care and will consider the long-term impact of mental illness on individuals. It will explore research on the non-acute phases of illness, psychosocial treatments, rehabilitation, recovery, and the integration of clinical and community care.

Chapter 2, *Addictions*, will describe the development of an academic Division of Substance Abuse that started with the pioneering work of Herbert Kleber and culminated in the construction of a Substance Abuse Center within the CMHC. This program is now the largest academic component of the CMHC. The chapter will tell the story of how an academic program may lead the way for development in a community mental health center by redefining the target population and practice in an essential area. It will summarize the role of the academic program in developing treatment approaches for addictions and co-occurring disorders.

Chapter 3, *Forensic Services*, relates the development of a law and psychiatry program that has flourished to the present point of annually offering subspecialty

training targeted at four graduate psychiatry fellows. This chapter will cover the development of competency evaluations and jail diversion programs and contributions to the debate on involuntary outpatient treatment. In addition, it will describe its critical role in risk management and the ethics of community practice.

The fourth chapter, Neurobiological Research, describes the development of the Ribicoff Research Facility and the contributions of neurobiological research to new and improved treatments. The chapter will highlight the translation of basic work into clinical research and clinical research into practice. It will summarize the impact of research on treatment of the seriously mentally ill and will review the current debate on old versus new antipsychotic drugs.

Chapter 5, Epidemiology, Services Research, Prevention and Public Health, will follow the history of services research starting in the 1970s leading to and including studies of early detection, prevention, community development, the epidemiology of psychiatric disorders in the community and services utilization. The chapter will highlight the influence of a population perspective on services and the impact of a public health approach on patient care.

In Chapter 6, Ethnicity, Health Disparities and Cultural Competence, the authors will cover the concept of multicultural care in a community setting. The chapter traces the origins of special services such as the Hispanic and Hill clinics that developed as programmatic responses to the problem of barriers to care. It also highlights the relationship of professional services to the faith-based community. It discusses disparities in health care outcomes for minorities and offers strategies, including cultural competence, to eliminate them.

Chapter 7, A Public–Academic Partnership, will discuss 40 years of partnership between the State of Connecticut and the CMHC and will suggest how policy for our academic mental health center should be formulated. It will summarize the State's view of the academy and will define approaches to defining the mission of the CMHC. The authors will provide a brief history of major policy periods such as the community support programs of the 1980s, Medicaid and privatization in the 1990s, and the current transformation agenda stemming from the federal government's New Freedom Commission.

Chapter 8, Public Psychiatry Training and Education, provides a history that starts in the 1970s and traces the introduction of social and community psychiatry into general psychiatric training. It will discuss the relationship of public psychiatry to general psychiatric education. It will also provide an overview of training public sector professionals for the unique public sector context.

In Chapter 9, the Future of Academic Public Psychiatry, the authors will offer a summary and a vision of the future of the CMHC and of public psychiatry. They will discuss the viability of the community mental health center model of academic–state partnership, while clarifying commitments to the partnership that are necessary for the collaboration to have some chance of success.

## Significance

It is our contention that academic contributions to the development of public psychiatry have been manifold and important. Two obvious examples of this are the contribu-

tions of academic programs in substance abuse and forensic services to the evolution of systems and services over the past two decades. Twenty years ago, the target population of community mental health centers was practically and exclusively made up of individuals with serious mental illness. Few, if any, individuals with substance abuse problems or legal problems entered treatment. Now, most patients at the CMHC have co-occurring disorders and are involved in some way in the criminal justice system. It was academic programs in these two arenas that prepared the CMHC for present public sector practice.

Other academic programs have also made signal contributions. Neurobiological research has contributed new, effective pharmacologic treatments, when 40 years ago, psychotherapy was the norm. Research on chronic illness has enhanced our understanding of the possibility of recovery and strategies for achieving it. Epidemiology has placed disorders in a population perspective and emphasized the concept of disease burden, which highlights the problem of psychosocial disability in society. Services research has evaluated the significance of system development, among other matters, and found it wanting, contributing to the movement to transform the “de facto,” “fragmented” system of care as we presently know it. These are examples that come to mind as we enter the process of documenting the academic programs at the CMHC. In the chapters that follow we intend to reemphasize the idea that academic programs make substantial contributions to public psychiatry.

Further, academic programs and the initiative of academic psychiatrists in seeking grant support are instrumental in leveraging resources to supplement existing state-funded programs. A good example of this is the development of housing resources over the past 11 years at the CMHC. Through the initiative of faculty and staff at the Center, residential slots for patients have been doubled from approximately 250 slots funded by state dollars to 500 slots. These additional housing resources have been funded through successful grant applications to the federal Department of Housing and Urban Development. The federal resources amount to about \$25M over the 11-year period.

Given the limitations of current knowledge, not least of the contributions that academic programs can make to public psychiatry is the catalytic role academic programs play in the translation of new research and discoveries into practice. Translation is a challenge for everyone. Academic centers embrace it. At the CMHC, for instance, the professional staff now engage in a perennial process of reviewing current knowledge and recent discoveries, not only within the Center itself but nationwide, to consider which practices merit implementation. We now conceptualize this process on three levels: the patient, specific practices and programs. For example, at the individual patient and clinician level, we are progressively implementing a center-wide program of evidence-based medicine. We also introduce new practices when we believe research has documented their efficacy; a current example is a locally proven, neuro-cognitive enhancement therapy for individuals in vocational rehabilitation. At the program level, we now have introduced eight best-practice packages ranging from an ACT team and Integrated Dual Diagnosis Treatment, to an Early Intervention Program for Psychotic Disorders. Periodically, we conduct fidelity studies, when the technology exists, to assure adherence to models.

It is our hope that the vision and ideas about directions for public psychiatry, which emerge from the descriptions and analysis in the sections that follow, will be useful not only to the CMHC but also to public psychiatry in general.

